METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

Effective for dates of service on or after ~~January~~ August 1, 201~~75~~, the RVUs used are the Medicare RBRVS values published by the Centers for Medicare and Medicaid on its website for calendar year (CY) 2017 including any of those subject to a "lesser of" policy as published by CMS. ~~.~~ The DVHA will recognize site of service differentials such that it will utilize the Non-Facility values for services provided in the physician office and facility RVUs to providers when place of service is an inpatient hospital, outpatient hospital, emergency room, ambulatory surgical center, inpatient psychiatric facility, nursing facility or skilled nursing center. DVHA generally also follows Medicare's policy of discounting RVUs to reflect non-physician payments. While DVHA generally has adopted the same Medicare discount amounts, DVHA may deviate from Medicare, for policy reasons, as to the magnitude of discounting among different non-physician clinicians paid via the RBRVS system. ~~The DVHA will follow Medicare's payment logic of using the lesser of the RBRVS or OPPS RVU values for those select procedures subject to the policy.~~

~~The GPCIs used are 1.000 for Work, 1.004 for Practice Expense and 0.682 for Malpractice Insurance.~~

Effective with dates of service on or after ~~January~~ August 1, 201~~75~~, the DVHA will use one conversion factor, referred to as the standard conversion factor, for DVHA covered services payable in the RBRVS methodology. The DVHA will pay for these services using a conversion factor of $28.71 multiplied by the RVU value on file with DVHA as referenced in the first paragraph on this page. Each RVU will be multiplied by the appropriate geographic practice cost index (GPCI). The updated GPCIs are 1.000 for Physician Work, 1.015 for Practice Expense and 0.595 for Malpractice Insurance.

Effective with dates of service on or after October 1, 2016, the DVHA ~~will implement~~implemented a second conversion factor of $32.59 that will be paid only to eligible enrolled Vermont Medicaid providers, for selected evaluation and management services, who ~~must~~ attest to being a primary care ~~physician~~providers. As of August 1, 2017, the primary care conversion factor will be raised to $35.8887, consistent with Medicare's CY2017 conversion factor. ~~by one of the following~~: The calculations with the RVUs and GPCIs will be identical to those described above, but a higher rate will be paid as a result of using a different conversion factor specific to these targeted services and providers...

~~1. Board certification as a primary care physician by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA) or;~~
~~1. Have furnished evaluation & management (E&M) and vaccine administration services that equal at least 60% of the Medicaid codes billed during the most recently completed fiscal year.~~

~~If the provider meets these conditions, then the services paid using the conversion factor of $32.59 are those covered and separately payable by Vermont Medicaid and are within the range of E&M Codes from 99201 through 99499 or vaccine administration codes from 90460 through 90474.~~

~~When the $32.59 rate is used, there is no site of service adjustment. Reimbursement is always made using the RVUs associated with the office setting.~~

~~Depending upon the provider billing the service, the DVHA modifier pricing logic may also apply.~~

Information on ~~A~~all rates, including those identified as being eligible for the primary care conversion ~~are~~factor, are published at http://dvha.vermont.gov/for-providers. ~~.~~ Information for providers wishing to attest to being eligible for the primary care conversion factor are published at http://vtmedicaid.com/assets/provEnroll/EPCPAttestForm.pdf~~VTMedicaid.com/Provider Enrollment/Data Maintenance Forms/EPCP Self-Attestation Form.~~

27. Anesthesia

Payment is made at the lower of the actual charge or the Medicaid rate on file. Effective for dates of service on or after January 1, 2012, the DVHA will reimburse qualified providers who administer anesthesia services covered by the DVHA using the

Medicare payment formula of (time units of service + base unit) multiplied by a conversion factor. The units of service billed are based on Medicare billing requirements. The base unit values used by DVHA are those put in place by Medicare effective January 1, 2012. The DVHA will follow Medicare's changes to the base unit values by updating the base units each January.

1. The DVHA will not use Medicare's conversion factor for Vermont, but rather a conversion factor of $18.15.

All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

~~TN~~GCR# ~~16-0021~~17-061- Effective Date: ~~10/01/16~~08/01/2017

Supersedes

TN# ~~15-013~~16-002- Approval Date: ~~12/20/16~~N/A